Behavioral Health-Related Preauthorization—Initial Request

INSTRUCTIONS: Complete and submit the form below via email (see email addresses at the bottom of the page) with relevant clinical notes and medical necessity information. Once we receive this form, we have these decision days to make a benefit determination unless an expedited review is requested:

- **For Commercial Plans:** 14 days (Utah), 2 business days (Idaho), 10 days (Nevada), 5 business days (Colorado)
- **For Medicare:** 14 days (All States)

For an expedited review, provide the phone number of someone who can immediately discuss the case (not a general office or answering service) **AND** include a letter or documentation from a medical provider explaining how/why the usual days (see above) would:

- Jeopardize the life, health, or ability to regain maximum function; and/or
- Threaten the member's ability to attain, maintain, or regain maximum function; and/or
- Subject the member to severe pain that could not be adequately managed without the requested services.

Today's Date (mm/dd/year) Dates of Service (mm/dd/year) to

Contact Name Email

Area Code/Ph # Area Code/Fax#

Immediate Contact Area Code/Ph # (required for expedited request)

PATIENT INFORMATION

Patient Name Date of Birth (mm/dd/year) Male Female City/State

Primary Insurer ID# Plan

Secondary Insurer ID# Plan

PROVIDER INFORMATION

Requesting Provider NPI# Area Code/Ph#

Complete Address

Service Provider/Facility NPI# Area Code/Ph#

Complete Address

REQUESTED SERVICES

Level of Care Requested*:

Describe below why this requested care level is appropriate for this patient:

***Medicare members only:** Intensive outpatient and partial hospitalization do not require preauthorization, and residential treatment is not covered.

CLINICAL INFORMATION

	Facility	Type of Service	Type of Treatment	Dates of Service
Previous Treatment			Psych Substance Use	
			Psych Substance Use	
			Psych Substance Use	

Current Symptoms: Provide diagnostic codes for current behavioral health symptoms and/or medical complications from substance use.

How long have these symptoms/complications been present?

Does the patient have any current legal issues? Yes No If yes, describe

What is the patient's current job, school or caregiver status, and living arrangement?

Does the patient currently have support? Yes No If not, why?

Is the patient in a high-risk environment? Yes No If yes, explain

Any change in the clinical issues described above in the past 30 days? Yes No If yes, explain

DOCUMENTATION SUBMISSION

Submit completed form with relevant clinical notes and medical necessity information via email as follows:

- For Commercial Plans (Large Employer, Small Employer, Self-Funded, and Individual): commercialUMintake@imail.org
- For Select Health Community Care (Medicaid) or Children's Health Insurance Program (CHIP): medicaidUMintake@imail.org
- For Select Health Medicare: medicareUMintake@imail.org

Reduce turnaround time for preauthorizations by using CareAffiliate®. Some preauthorization requests even qualify for auto-approval. To learn more, email **careaffiliate@selecthealth.org**.

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